MADAGASCAR AND HIV/AIDS

Key Talking Points

In Madagascar, although the HIV prevalence rate is still relatively low, the possibility of an explosive epidemic remains.

- The HIV prevalence rate rose from 0.02 percent in 1989 to 0.07 in 1995, to 0.12 in 1997.
- High rates of STI (over 14% of pregnant women and 35% of sex workers tested positive for syphilis in some regions of the country) create ideal conditions for the spread of HIV.
- The UNAIDS epidemiological model (Epimodel 2) estimates that 1,900 people have died of AIDS-related diseases since the beginning of the epidemic—600 of them in 1997.

Women and HIV/AIDS In 1996, 0.1 percent of pregnant women in urban and rural antenatal clinics tested positive for HIV. The numbers of women and men who are HIV-positive are roughly equal.

Children, Youth and HIV/AIDS Forty-seven percent of the total Malagasy population are under age 15. The HIV epidemic has a disproportionate impact on children, causing high morbidity and mortality rates among infected children and orphaning many others.

USAID is one of the largest supporters of HIV/AIDS programs in Madagascar, contributing $400,000 in FY 1997. In 1996 USAID launched a condom sales program, targeting young adults and other groups at risk of HIV/AIDS infection. The program resulted in sales of over three million condoms within 18 months of start-up.

National Response Many people in Madagascar still do not believe that HIV/AIDS is a national problem. Because of its relative isolation, Madagascar may have been protected from an early onslaught of HIV; however, high levels of risk in the population signal a rapidly growing HIV/AIDS epidemic. It is not too late to stop the epidemic in its tracks. What is needed is political leadership and commitment, increased resources, and a government agency with authority to lead and coordinate a multisectoral response to the epidemic.

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MADAGASCAR AND HIV/AIDS

Country Profile

Madagascar is one of the fastest growing countries in Africa, with a population projected to increase 43 percent by 2010 and double by 2025. Suffering from pervasive poverty, high population growth and poor agricultural practices, the Malagasy people have experienced a marked decline in their standard of living over the past quarter century. Real per capita income fell by more than 40 percent between 1970 and 1995, placing the country among the world's poorest.

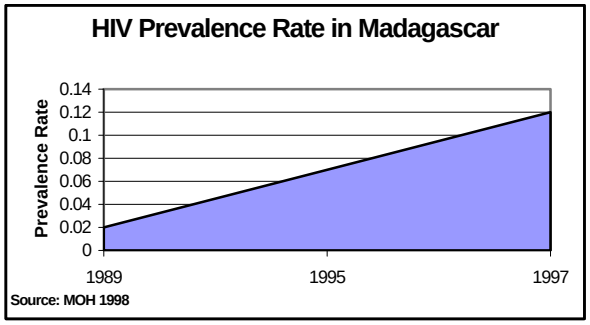
Despite improvements in a number of health indices in recent years, Madagascar continues to face serious health sector problems with substantial implications for its economic and environmental well being. The public sector and NGOs provide services at approximately 2,400 health facilities nationwide, but the quality of these services often falls below standard and access to services remains low (38 percent). Sixteen percent of Malagasy children die before age 5. This rate is ten times the rate for developing countries as a whole, and more than 20 times the rate for industrialized countries. Nearly one million Malagasy children are malnourished—well over half the under-5 age group. Full child immunization is 36 percent, one in five children have received no immunizations by the their first year, and only 23 percent of diarrhoeal infections are treated with oral rehydration solution.

Madagascar suffers from a high infant mortality rate (96 per 1,000 live births) and a low life expectancy (52 years). Malagasy women give birth to an average of six children, and one in three adolescents give birth before reaching age 18. Fully two-thirds of births to Malagasy women are classified as high risk, with increased chance of mortality for the mother (one women for every 204 children born) and/or infant. Recent studies indicate that 45 percent of Malagasy women in some regions currently have a sexually transmitted infection (STI), a common vector for the transmission of HIV.

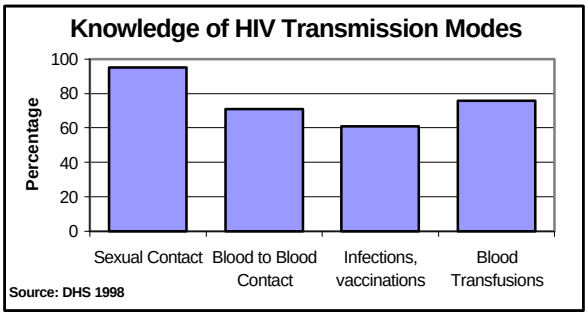
HIV/AIDS in Madagascar

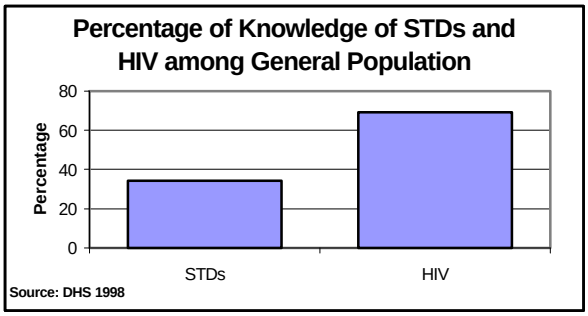
In Madagascar, HIV is just beginning to spread among the general population. Initially the country may have been protected by its relative isolation, but the high levels of risk in the population are signaling that the epidemic could continue to grow at a relatively fast rate. The HIV prevalence rate rose from 0.02 percent in 1989 to 0.07 in 1995, to 0.12 in 1997. As in many African countries, the limitations of the surveillance system make it difficult to determine the real rate of the spread of infection. In 1997, UNAIDS and WHO, working with the Government of Madagascar, developed estimates of spread of the epidemic using Epimodel 2. Although HIV prevalence rate is still relatively low, the possibility of an explosive epidemic remains, given the high rates of STI prevalence.

- In 1997, over 14% percent of pregnant women tested positive for syphilis in some regions.
- Among sex workers, syphilis prevalence rates ranged as high as 35 percent in some regions in 1997.
- Using Epimodel 2, UNAIDS estimates that more than 8,600 Malagasy individuals are living with HIV—2,200 of them with AIDS. However, only 233 people are reported to have tested positive for HIV.
- Using Epimodel 2, UNAIDS estimates that 1,900 people have died of AIDS-related diseases since the beginning of the epidemic—600 of them in 1997.



AIDS is still a foreign concept in Madagascar. According to the Ministry of Health, there is no local term for the disease and many people think of it as a foreigners' problem which has no relevance to their own lives. This denial has the potential to exacerbate the spread of HIV.

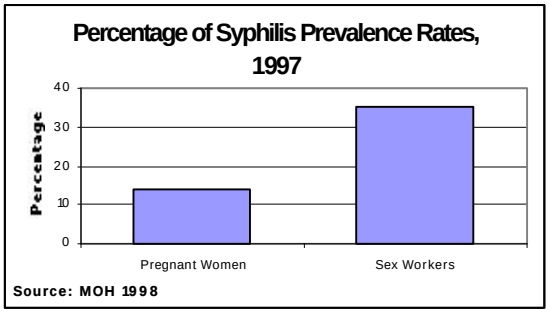




Women and HIV/AIDS

Women's low social and economic status, combined with greater biological susceptibility to HIV, put them at increased risk of infection. Deteriorating economic conditions, which make it difficult for women to access health and social services, compound their vulnerability. In general, women suffer from greater poverty due to lack of access to critical resources such as land, credit, extension services, and technology. This in turn limits their access to health and social services, in addition to leading some women to sex work as a means of survival. In one town of 37,000 inhabitants, 700 women were registered as prostitutes.

- In a recent survey, 35 percent of sex workers reported that they never use condoms with any type of client, and nearly two-thirds never use them with regular partners.
- In 1996, 0.1 percent of pregnant women in urban and rural antenatal clinics tested HIV-positive.
- The numbers of women and men who are HIV-positive are roughly equal.
- Some 14 percent of pregnant women in a recent survey reported casual partners, and more than nine out of ten never used condoms during those encounters.



Children, Youth and HIV/AIDS

Forty-seven percent of the total Malagasy population is under age 15. The HIV epidemic has a disproportionate impact on children, causing high morbidity and mortality rates among infected children and orphaning many others.

Approximately 30 to 40 percent of infants born to HIV-positive mothers will also become infected

with HIV, and most of them will develop AIDS and die within two years.

- UNAIDS estimates that 370 children under age 15 are living with HIV/AIDS.
- UNAIDS estimates that 1,300 children have been orphaned by HIV/AIDS.

Most HIV infections occur among young people in their teens and 20s. Young women are particularly vulnerable. According to behavioral surveys, sexual activity begins early (around age 15 for the majority of women) and premarital pregnancy is common. Recently the government has taken special steps to increase the level of HIV/AIDS knowledge among young adults. Special reproductive health services for 10- to 24-year-olds have been established in several areas of the country. The aim of these special youth-friendly clinics is to spread the word about HIV and instill a norm of safe behavior quickly, before the virus can take hold among young adults in Madagascar.

Socioeconomic Effects of AIDS

About 90 percent of reported AIDS cases worldwide are 20 to 49 years old. Since this age group constitutes the most economically productive segment of the population, an important economic burden is created. Productivity falls and business costs rise—even in low-wage, labor-intensive industries—as a result of absenteeism, the loss of employees to illness and death, and the need to train new employees. The diminished labor pool affects economic prosperity, foreign investment, and sustainable development. The agricultural sector likewise feels the effects of HIV/AIDS; a loss of agricultural labor is likely to cause farmers to switch to less-labor-intensive crops. In many cases this implies switching from export crops to food crops—thus affecting the production of cash and food crops.

There are also many private costs associated with AIDS, including expenditures for medical care, drugs, funeral expenses, etc. The death of a family member leads to a reduction in savings and investment, and increased depression among remaining family members. Women are most affected by these costs and experience a reduced ability to provide for the family when forced to care for sick family members. And AIDS adversely affects children, who lose proper care and supervision when parents die. Some children will lose their father or mother to AIDS, but many more will lose both parents, causing a tremendous strain on social systems. At the family level there will be increased pressure and stress on the extended family to care for these orphans; grandparents will be left to care for young children and 10- to 12-year-olds become heads of households.

(For country-specific information on the socioeconomic impact of HIV/AIDS refer to the *analysis* presented by the Policy Project.)

Interventions

National Response

The Programme National de Lutte contre le SIDA (PNLS) was formed in the early 1990s. With a central office located in the Ministry of Health, the PNLS has regional offices in several provinces. The main responsibilities of the PNLS include planning, coordinating, monitoring, training, resource distribution, and evaluation of programs. The PNLS is also responsible for developing short- and medium-term plans and coordinating a multisectoral approach to HIV/AIDS prevention and care in Madagascar.

According to UNAIDS, the PNLS is not fully or appropriately staffed. Rather than focusing only on coordination, the PNLS is also beginning to implement several activities. In 1998 the PNLS held a multisectoral meeting with several other ministries and a National Colloquium on AIDS and Religion. The PNLS also provided training in program management to 18 representatives of

NGOs, and funded selected activities of all but a few of them. Currently, the program is also providing training to physicians in STI syndromic management. In collaboration with the Ministry of Education, UNICEF, and local NGOs, the PNLS recently initiated HIV prevention programs focused on youth. Prevention activities are being carried out in school "clubs" and through peer education programs.

The Ministry of Health has also received a significant World Bank loan to enhance its health initiatives. The PNLS is using part of these funds to implement several multisectoral projects. As part of the World Bank project, the PNLS is reformulating the national STD treatment guidelines and community-based components.

Although the PNLS is attempting to strengthen its multisectoral approach, to date the multisectoral committee has existed on paper only. Significant leadership from the Ministry of Health and the PNLS will be needed to strengthen the multisectoral approach and continue to build a strong HIV/AIDS prevention program in Madagascar.

Donors

Multilateral and bilateral donors are actively engaged in HIV/AIDS activities in Madagascar. According to a UNAIDS/Harvard study, bilateral organizations contributed the following in 1996-97:

Organization	Amount US$ 1996-97
USAID	400,000
EU	348,000
France	59,400
Total	**807,400**

Bilateral organizations' contributions 1996-1997

USAID's HIV/AIDS funding for FY 1998 was $500,000. Since the inception of its HIV prevention programming, the mission has provided strong leadership in articulating HIV/AIDS prevention priorities among other donors.

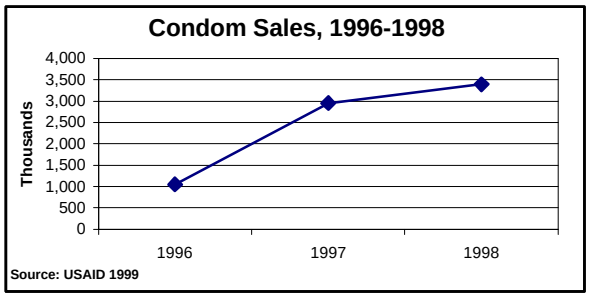
In 1996 USAID launched a condom sales program, targeting young adults and other groups at risk of HIV/AIDS infection. The program resulted in sales of over three million condoms within 18 months of start-up.

The mission has also pursued a highly successful family planning and condom promotion campaign. In 1999 USAID will continue to implement the social marketing program for condom use, and add new behavior change activities in key "hot zones" of the country and prevention activities targeting high-risk populations.

USAID/Madagascar will also contribute to the achievement of a sustainable reduction in HIV/AIDS transmission among key populations through interventions that:

- Improve and expand availability, quality, and use of STI prevention and treatment services.
- Build local capacity to carry out programs.
- Promote the adoption of HIV/AIDS prevention policies, services, and practices.

USAID is also in the process of developing indicators and targets for HIV/AIDS and STI prevention to measure the success and effectiveness of HIV prevention activities being implemented in Madagascar.


Condom Sales, 1996-1998
Thousands
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
1996
1997
1998
Source: USAID 1999

UNAIDS has a coordinating Theme Group based in Madagascar. The group, chaired by WHO, consists of representatives from UNDP, UNICEF, WHO, The World Bank, UNESCO, UNFPA, and the ILO. Support from UNAIDS cosponsors in 1996-1999 included the following (some of the numbers are still not available):

Organization	Amount US$ 1996-97	Amount US$ 1998-99
World Bank	925,000	190,000
UNDP	189,000	N/A
UNAIDS	100,000	140,000
UNICEF	75,000	152,000
WHO	71,000	N/A
ILO	6,630	N/A
UNESCO	N/A	5000
Total	**1,366,630**	**487,000**

UNAIDS cosponsor support 1996-1999

The UNAIDS Theme Group has proposed to sponsor a project aimed at reorganizing the PNLS, and is also assisting the PNLS in developing several multisectoral projects, with World Bank loan support. Currently UNAIDS is lobbying the World Bank and national authorities to develop and implement a participatory planning process. In September 1999 UNAIDS, in collaboration with WHO and with the participation of Rwanda, Republic of Congo, Burundi, Seychelles, Reunion, Mauritius, and Comores, will sponsor a regional workshop on the second-generation HIV surveillance system, with emphasis on behavioral surveillance.

WHO provides technical leadership for the sector and sponsors the UNAIDS advisor to the National AIDS Control Program. WHO also supports the expansion of family planning services and other activities directed at youth and adolescents; population education; information, education, and communication (IEC) activities; and data collection.

UNICEF has both behavior change communication (BCC) and AIDS specialists on staff and is actively engaged in national AIDS prevention planning and programming. UNICEF has also collaborated closely with USAID staff in the development of survey instruments that provide data comparable to the DHS.

Other donors involved in HIV/AIDS prevention include the IDA, UNFPA, France and the GTZ.

Private Voluntary Organizations (PVOs), Nongovernmental Organizations (NGOs) and Research Institutions

A number of PVOs implement activities funded by multilateral and bilateral donors. Some of the major USAID cooperating agencies are Deloitte & Touche and Population Services International, which is currently implementing an active social marketing effort and Family Health International. *See attached preliminary chart for PVO and USAID cooperating agencies HIV/AIDS activities. This list is evolving and changes periodically.*

NGOs and community-based initiatives receive funding from a variety of sources, including the PNLS, and play a significant role in carrying out HIV prevention and care activities in Madagascar. A number of sex worker associations work in various cities to protect the human rights of sex workers. Due to lack of funding and difficulties in organizing, however, these organizations are struggling to survive.

Challenges

Major constraints to HIV/AIDS control in Madagascar include the following:

- Many people in Madagascar still do not believe that HIV/AIDS is a national problem. The head of the PNLS states that it is very difficult to institute behavior change programs in this type of environment.
- Poverty and a lack of resources to address HIV/AIDS and other health and development problems.
- The PNLS lacks high-level commitment and coordination capability due to lack of resources and support.
- Poor access to health and education programs.
- Inadequate access to comprehensive community-based care and referrals for PLWHA.

The following gaps must be filled in order to mount an effective response to HIV/AIDS in Madagascar:

- Political leadership and commitment and increased resources.
- A government agency with the authority to lead and coordinate a multisectoral response to the epidemic.
- A multisectoral approach.
- HIV/STD prevention and control efforts that target high-risk groups such as sex workers and symptomatic STI patients, particularly men.
- Integration of HIV prevention with reproductive health and child survival programs.
- Behavior change interventions are needed to complement all IEC activities.

The Future

Madagascar may have been protected from an early onslaught of HIV because of its relative isolation; however, high levels of risk in the population are sending a wake-up call to all who are listening. The time to act is now.

It is not too late to stop the epidemic in its tracks and reverse the rapidly growing HIV/AIDS epidemic. Strong leadership and commitment is vital to slowing the epidemic and awakening the nation to the devastation that can be caused by HIV/AIDS.

Important Links and Contacts

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3. PNLS: Dr. Rasamilalao Désiré, Director
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Madagascar

Organization	Intervention																
	Advoc.	BCI	Care/S	Training	Cond.	SM	Eval.	HR	IEC	MTCT	Research	Policy	STD	VCT	Orphan	TB	Other
Cooperating Agencies																	
IMPACT/Horizons				X							X		X				
MACRO International											X						
Peace Corps	X			X					X								
CMS			X			X			X								
PVOs/NGOs																	
MDM		X		X	X	X			X				X				
MSFch		X		X		X							X				X
UNICEF		X		X		X			X				X				

KEY:

Advoc.	Advocacy	**MTCT**	Mother to Child Transmission activities
BCI	Behavior Change Intervention	**Research**	HIV/AIDS research activities
Care/S	Care & Support Activities	**Policy**	Policy monitoring or development
Training	HIV/AIDS training programs	**STD**	STD services or drug distribution
Cond.	Condom Distribution	**VCT**	Voluntary counseling and testing
SM	Social Marketing	**Orphan**	AIDS orphan activities
Eval.	Evaluation of several projects	**TB**	TB control
HR	Human Rights activities	**Other**	(I.e. blood supply, etc.).
IEC	Information, education, communication activities		